

**[Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company] (the Company)  
Select Risk Questionnaire for Stop Loss Insurance**

Name of Applicant: \_\_\_\_\_ Proposed Effective Date: \_\_\_\_\_ Proposed Specific Deductible: \$ \_\_\_\_\_

This Select Risk Questionnaire ("Questionnaire") must be completed and returned to the Company by the Applicant no earlier than **[45]** calendar days prior to the Proposed Effective Date.

The Company will rely on the information supplied to:

- (a) evaluate and determine whether to issue a stop loss insurance policy to the Applicant;
- (b) adjust specific deductibles for (or exclude losses related to) individuals with known medical conditions;
- (c) waive performing normal activities requirements under any issued stop loss insurance policy; and/or
- (d) determine the premium rates and other underwriting terms and conditions for any issued stop loss insurance policy.

This information will be included in and shall become a part of any stop loss insurance policy issued by the Company. Stop loss insurance will not begin unless and until the Company approves the application for stop loss insurance.

Complete Attachment A of this Select Risk Questionnaire, with respect to any individuals (employees, COBRA participants, FMLA or other continuees, retirees or dependents) satisfying any of the following criteria and expected to be covered under the Applicant's self insured health care plan on the Proposed Effective Date:

- (a) Any individual who has received benefits under the Applicant's medical plan during the last 12 months (including any pending charges not yet paid) exceeding **[the lesser of \$20,000 or] [50%]** of the Proposed Specific Deductible;
- (b) Any individual confined in a medical facility or institution during the past 30 days or expected to be so confined at any time during the period commencing on the date this Questionnaire is signed and ending on the 90<sup>th</sup> day after the Proposed Effective Date;
- (c) Any employee absent from work due to illness or injury on the day this Questionnaire is signed;
- (d) Any individual physically or mentally unable to perform all of the normal activities of an individual who is in good health on the day this Questionnaire is signed; or
- (e) Any individual diagnosed with any serious illness or injury including but not limited to any of the following diagnoses:

ICD-9 Code	Diagnosis	ICD-9 Code	Diagnosis	ICD -9 Code	Diagnosis
001-139	Infectious Diseases/AIDS/HIV	290-299	Mental & Nervous Disorders/Psycho-neurotic	640-670, V31-V37	High Risk Pregnancy/Complications
140-239	Malignancies/Cancer/Leukemia	320-389	M.S./Nervous System/Encephalitis	719-730	Connective Tissue/Back Disorder/Osteomyelitis
250	Uncontrolled Diabetes/Complications	393-448	Heart Disease/CHF/Cardiomyopathy/Cerebrovascular Disease/Stroke	740-779	Congenital Anomalies/Newborn Complications
272.7	Gauchers Disease/Malabsorption Syndrome	490-496	Primary Pulmonary Hypertension/Respiratory	800-854, 952-953	Intracranial/Spinal Cord Trauma/Paralysis
277	Cystic Fibrosis	555-558, V44	Severe GI Disorders/Regional Enteritis	860-950	Major Trauma/Amputation/Burns
278 & 783	Hyperalimentation/Feeding Disorders	570-579	Chronic Liver/Pancreatic Disease/Hepatitis	996-997, V42	Organ Transplants
286	Hemophilia/Blood Disorders	582-588	Renal Disease/Failure/Dialysis		

To assist in identifying individuals who satisfy any of the criteria noted above when completing Attachment A, the Applicant should obtain and analyze, without limitation, pending claim reports, large claim reports, precertification, large case management and other utilization review/management reports, subrogation reports, employee attendance records, sick leave and disability reports. As an alternative to completing Attachment A, the Applicant may attach a report(s), acceptable to the Company, that contain(s) the information requested for Attachment A. If this alternative is chosen, the report(s) must be generated within **[45]** days of the Proposed Effective Date and individuals satisfying any of the above criteria must be highlighted on the report.

As an authorized representative of the Applicant, I hereby warrant and represent that the information included on Attachment A or any reports supplied is complete and accurate and that nothing has been knowingly or intentionally omitted. I also acknowledge that failure to disclose complete information, or providing inaccurate information, may result in the:

- (a) denial of stop loss reimbursements for losses related to (or the adjustment of specific deductibles for) certain individuals;
- (b) revision of the terms or conditions of any issued stop loss insurance policy; or
- (c) rescission of stop loss insurance

as of the effective date of such insurance.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

